PREADMISSION EVALUATION FOR NURSING FACILITY CARE

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<< To be completed by TennCare >>

APPROVAL DECISION		LEVEL	APPROVAL DATE		END DATE	REVIEWER	REVIEW DATE
YES	NO	1 2 H P	_____	--	_____	_____	_____
YES	NO	1 2 H P	_____	--	_____	_____	_____
YES	NO	1 2 H P	_____	--	_____	_____	_____
YES	NO	1 2 H P	_____	--	_____	_____	_____

<< **NOTE**: This PAE must be used within 90 days of the "APPROVAL DATE". >>

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SERVICE REQUESTED

[ ] Level 1
[ ] Level 2
[ ] HCBS Waiver
[ ] PACE Program

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PROVIDER Name_____

Street Address_____

City/State/Zip Code_____

Provider Number_____ Phone_____ Fax_____

PATIENT Name_____
(Last) (First) (Middle)

Street Address_____

City/State/ Zip Code_____ Phone Number_____

Medicaid Number_____ Soc. Sec. Number_____ Date of Birth _____ Age____

DESIGNEE Name_____
(Last) (First) (Middle)

Street Address_____

City/State/ Zip Code_____ Phone Number_____

I certify that I do NOT want a designated correspondent._____
Signature

ADMISSION

[ ] New admission – admitted from home, hospital, or another Nursing Facility
[ ] Readmission after discharge for hospitalization
[ ] New Medicaid Eligible – had been private pay or had other payor
[ ] Former Medicaid Eligible – now Medicaid Eligible after being private pay
[ ] Expiration of PAE
[ ] Change in level of reimbursement
[ ] Other (specify):_____

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Send To: TennCare Long-Term Care Division:

By FAX: (615) 741-9260
By U.S. Mail: P.O. Box 450, Nashville, TN 37202-0450
By Other Delivery: 310 Great Circle Rd, Nashville, TN 37243

CAPABILITIES: (Circle one answer: A = Always; U = Usually; UN = Usually Not; N = Never)

TRANSFER **A U UN N** Can patient transfer without physical help from others?

days/week physical assistance is required_____

MOBILITY **A U UN N** Can patient walk without physical help from others?

days/week physical assistance is required_____

A U UN N Can patient use a wheelchair without physical help from others?

days/week physical assistance is required_____

EATING **A U UN N** Can patient place food/drink in the mouth without physical help from others?

days/week physical assistance is required_____

TOILETING **A U UN N** Can patient use a toilet without physical help from others?

days/week physical assistance is required_____

A U UN N IF INCONTINENT, can patient do incontinence care without physical help from others?
Type: [ ] Bowel [ ] Bladder
days/week physical assistance is required_____

A U UN N INDWELLING CATHETER or OSTOMY if present: Can patient do self-care without physical help from others?

days/week physical assistance is required_____

COMMUNICATION **A U UN N** Can patient express basic needs and wants (e.g., assistance with toileting; presence of pain) ?

days/week problem occurs_____

A U UN N Can patient understand and follow very simple instructions (i.e., how to perform basic activities of daily living) without continual staff intervention?

days/week problem occurs_____

ORIENTATION **A U UN N** Is patient oriented to person (remembers name; recognizes family) and place (knows is in nursing facility)?

days/week problem occurs_____

MEDICATIONS **A U UN N** Can patient self-administer medications with limited help from others (e.g. reminding, encouragement, reading labels, opening bottles, handing to patient, reassurance of dose)?

days/week problem occurs_____

A U UN N INSULIN patients only: If on a fixed dose, can patient inject insulin with a pre-filled syringe or if on sliding scale, can patient draw up and inject insulin?

days/week problem occurs _____

BEHAVIOR **A U UN N** Does patient require continual staff intervention for a persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement) ?

days/week intervention is required_____

NURSING & REHABILITATIVE SERVICES: Check all that apply and indicate frequency.

[ ] Catheter care, indwelling …….._____ X daily or _____ X weekly

[ ] Dressings, sterile, Stage 3 or 4 decubiti……..……..._____ X daily or _____ X weekly

[ ] Dressings, sterile, multiple Stage 2 decubiti…….._____ X daily or _____ X weekly

[ ] Dressings, sterile, other…….._____ X daily or _____ X weekly

[ ] Injections, fixed-dose insulin……._____ X daily or _____ X weekly

[ ] Injections, sliding scale insulin….……._____ X daily or _____ X weekly

[ ] Injections, other: IV, IM, subQ……..……_____ X daily or _____ X weekly

[ ] Intravenous fluid administration……_____ X daily or _____ X weekly

[ ] Isolation precautions……..……_____ X daily or _____ X weekly

[ ] Occupational therapy by OT or OT assistant……..…….._____ X daily or _____ X weekly

[ ] Ostomy Care……..……_____ X daily or _____ X weekly

[ ] Oxygen administration, stationary system……_____ X daily or _____ X weekly

[ ] Physical therapy by PT or PT assistant….…..……..……_____ X daily or _____ X weekly

[ ] Respiratory therapy by RT, RT asst., or nurse…….……_____ X daily or _____ X weekly

[ ] Suctioning, tracheal/tracheostomy……_____ X daily or _____ X weekly

[ ] Teaching catheter/ostomy care……..……_____ X daily or _____ X weekly

[ ] Teaching self-injection……..……_____ X daily or _____ X weekly

[ ] Total parenteral nutrition……..……_____ X daily or _____ X weekly

[ ] Tube feeding, gastrostomy or nasogastric……_____ X daily or _____ X weekly

[ ] Ventilator services……_____ X daily or _____ X weekly

[ ] Other:…….. ……_____ X daily or _____ X weekly

[ ] Other:…….. ……_____ X daily or _____ X weekly

[ ] Other:…….. ……_____ X daily or _____ X weekly

LEVEL 2 REQUESTS only: Indicate the daily skilled nursing or rehabilitative service for which Level 2 reimbursement is requested.

_____

_____

AGGRESSIVE BEHAVIOR: Circle yes or no.

YES **NO** Does the individual have an established and persistent pattern of aggressive behavior that has endangered the health or safety of others? If yes, attach a statement that describes such pattern of behavior and outlines specific care needs for the individual to ensure the health and safety of others.

I certify that the above information is accurate for the requested date of service.

Signature of physician, nurse, or PA_____ Date_____

PHYSICIAN'S CERTIFICATION OF NURSING FACILITY CARE

DIAGNOSES Primary_____

Other_____

_____

_____

_____

PROGNOSIS _____

ATTACHMENTS (Please submit the following attachments.)

1. Recent history and physical: A history and physical done within the past 12 months may be used if the patient's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement the history and physical and provide current medical information if changes have occurred since the history and physical.

2. Physician orders, including current medications.

PAE REQUEST DATE for Medicaid-reimbursed nursing facility care: _____

CERTIFICATION

I certify that the requested level of Nursing Facility care (or Waiver services or PACE program alternatives) is medically necessary for this patient.

Signature_____ Date of Signature_____

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<< **Complete the following section only if the PAE Request Date must be revised.** >>

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CERTIFICATION UPDATE

I certify that the patient's medical condition on the revised PAE Request Date is consistent with that described in the initial certification and that Nursing Facility care is medically necessary for the patient.

Revised PAE Request Date	Signature of Physician	Date of Signature

PASARR LEVEL I ASSESSMENT FOR MENTAL ILLNESS & MENTAL RETARDATION

MENTAL ILLNESS (Circle yes or no.)

YES NO Does the individual have a diagnosis of a major MENTAL ILLNESS (e.g., schizophrenia, paranoid state, bipolar disorder, atypical psychosis, major depression)? If so, indicate diagnosis._____

YES NO Does the individual have any presenting evidence of MENTAL ILLNESS, including disturbances in orientation, affect, or mood? Exclude individuals who have a primary diagnosis of dementia (including Alzheimer's disease and related disorders), and exclude individuals who have a secondary diagnosis of dementia (including Alzheimer's disease and related disorders) and who do not have a primary diagnosis of a major mental illness.

YES NO Has the individual had a history of MENTAL ILLNESS in the last 2 years?

MENTAL RETARDATION (Circle yes or no.)

YES NO Does the individual have a diagnosis of MENTAL RETARDATION?

YES NO Does the individual have any presenting evidence (cognitive or behavior functions) that suggests that the individual has MENTAL RETARDATION or a DEVELOPMENTAL DISABILITY? If there is a developmental disability, please describe it.
_____

YES NO Does the individual have any history of MENTAL RETARDATION or DEVELOPMENTAL DISABILITY that was manifested before age 22?

YES NO Has the individual been referred by an agency that serves persons with MENTAL RETARDATION or DEVELOPMENTAL DISABILITIES, and has the individual been deemed eligible for services of such an agency? If so, which agency.
_____

I certify that the above information is accurate.

Signature_____Date_____

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EXEMPTIONS (Complete this section only if Level I PASARR indicates mental illness or mental retardation and if there is an applicable exemption.)

I certify that the individual is exempt from the PASARR Level II assessment because of:

[ ] DEMENTIA: The individual has a primary diagnosis of dementia (including Alzheimer's disease and related disorders) based on neurological examination; or the individual has a secondary diagnosis of dementia (including Alzheimer's disease and related disorders) based on neurological examination and does not have a primary diagnosis of a major mental illness. Dementia is NOT ALLOWED as an exemption if the individual has, or is suspected of having, a diagnosis of mental retardation.

[ ] TERMINAL ILLNESS: The individual is terminally ill, has a medical prognosis that life expectancy will be 6 months or less, and is not a danger to self or others.

[ ] SHORT-TERM CONVALESCENCE: The individual is being admitted from a hospital for convalescent care not to exceed 120 days and is not a danger to self or others.

[ ] SEVERITY OF ILLNESS: The individual has a medical condition of such severity that it would prohibit participation in specialized services for mental illness or mental retardation (e.g., coma, ventilator-dependent, severe COPD, severe CHF, severe Parkinson's Disease, Huntington's Disease, or Amyotrophic Lateral Sclerosis) and is not a danger to self or others. Note: Please submit medical documentation.

Physician's
Signature_____Date_____